

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G246 8-21-59 et

7988

CERTIFICATE OF DEATH

Reg. Dist. No.

07971

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUPE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>12 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BOB</u> Middle <u>BOY</u> Last <u>ABNEY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>PAULINE OSBORN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>SEAGENT ACKMAN - ABERDEEN, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTRA UTERINE ANOXIA</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>26 HRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15, 1959</u> to <u>7/15, 1959</u> that I last saw the deceased alive on <u>7/15, 1959</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. P. Ross</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>I. R. ROSS, M.D.</u>		<u>HAUPE DE GRACE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/16/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence R. Harford</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>	
ADDRESS <u>Harford County MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harford</u>	

CERTIFICATE OF DEATH

1910-1911

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7989

CERTIFICATE OF DEATH

Reg. Dist. No. 07972

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles J Middle Badders Last Badders				4. DATE OF DEATH Month July Day 23 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6 1894	
9. AGE (In years, last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 6 Days 18 Hours 15 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SMILEY S. BADDERS				14. MOTHER'S MAIDEN NAME ELIZABETH GIBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-26-8027		17. INFORMANT SAMUEL S. BADDERS Address WHITE HALL, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular DUE TO and renal disease (c) ? INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21st, 1959 , to July 23rd, 1959 , that I last saw the deceased alive on July 23rd, 1959 , and that death occurred at 4:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				DATE SIGNED 7/23/59			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Haver de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/59		22c. NAME OF CEMETERY OR CREMATORY Ayres Chapel		22d. LOCATION (City, town, or county) (State) Dry Branch Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Hunt				ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR Jul 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hunt			

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CERTIFICATE OF DEATH

[Faint, illegible handwritten text throughout the form, likely bleed-through from the reverse side.]

[Faint, illegible signature in the bottom left corner.]

[Vertical text on the right margin, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07973

Reg. Dist. No.

8012

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Belle Harward Baxter</u>		4. DATE OF DEATH Month Day Year <u>July 27 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Harward</u>		14. MOTHER'S MAIDEN NAME <u>Harriet V. James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Paul B. Harlan, Churchville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia of extensive gangrene over the sacral area</u> DUE TO (b) <u>Vascular thrombosis</u> DUE TO (c) <u>Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>6 wks??</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>39</u> , to <u>July 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>59</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>		DATE SIGNED <u>July 27, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Rt. #2, Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>			

520



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7990

CERTIFICATE OF DEATH

07974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. LENGTH OF STAY IN 1b <i>3 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> d. STREET ADDRESS <i>823 D. Union</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Jane Beveridge Botsford</i>			4. DATE OF DEATH Month Day Year <i>7/8/59</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 24/1876</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			13. FATHER'S NAME <i>Daniel Beveridge</i>		
14. MOTHER'S MAIDEN NAME <i>Rebecca Hamilton</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO. <i>Unknown</i>			17. INFORMANT <i>Jane E. Botsford</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Congestive Bronchopneumonia</i> DUE TO (c) <i>Cerebral hemorrhage & hemiplegia right</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I (a) <i>Chronic myocarditis with arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>2 days</i> <i>4 days</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>July 4</i> , 19 <i>59</i> , to <i>July 8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 8</i> , 19 <i>59</i> , and that death occurred at <i>8 A</i> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>200 North Union Ave</i> DATE SIGNED <i>7/9/59</i> ACTUAL SIGNATURE <i>Frank Wolbert MD</i> PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT MD</i> <i>HAURE DE GRACE MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7/11/59</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill</i>	
22d. LOCATION (City, town, or county)		22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don, Harford</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WILLIAM B. BROWN

WHITE

MALE

AGE 65

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

WILLIAM B. BROWN

WHITE

MALE

AGE 65

DATE OF DEATH

PLACE OF DEATH

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Signature of Physician

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WILLIAM B. BROWN

WHITE

MALE

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Signature of Physician

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WILLIAM B. BROWN

WHITE

MALE

AGE 65

DATE OF DEATH

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Signature of Physician

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Signature of Coroner

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Signature of Burial

Signature of Interment

Signature of Burial

WILLIAM B. BROWN

WHITE

MALE

AGE 65

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

8013

CERTIFICATE OF DEATH

07975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground, d. STREET ADDRESS Apt # 1 Bldg 2005 Aberdeen Proving Ground, Md	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle EMIL Last BOY		4. DATE OF DEATH Month July Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct 8, 1882
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio-Engineer		10b. KIND OF BUSINESS OR INDUSTRY Radio-Engineer	
11. BIRTHPLACE (State or foreign country) Alsace Lorraine		12. CITIZEN OF WHAT COUNTRY? Naturalized American citizen	
13. FATHER'S NAME Jean Boy		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Edmund G Boy (Son)		Address Apt #1 Bldg 2005 Aberdeen PG Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis adenocarcinoma of lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **11 May**, 19**59**, to **8 July**, 19**59**, that I last saw the deceased alive on **8 July**, 19**59**, and that death occurred at **3:00 P.M.**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED **8 July 1959**

ACTUAL SIGNATURE D Hamaty Capt MC	M.D. US Army Hospital Aberdeen Proving Ground, Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/59	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE JUL 13 1959	24b. REGISTRAR'S SIGNATURE Carlina S. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8014

CERTIFICATE OF DEATH

07976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elena N. Branham		4. DATE OF DEATH Month Day Year July, 24 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Elisha Willis		14. MOTHER'S MAIDEN NAME Ella Adcox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Samuel C. Branham, Darlington Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) old age		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12 , 19 59 , to July 24 , 19 59 , that I last saw the deceased alive on July 21 , 19 59 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips MD		DATE SIGNED 7/25/59	
PHYSICIAN'S NAME (Type) Dudley Phillips MD		Darlington, Md.,	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July, 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel, Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McBrink		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the hospital or attending physician.

RECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, should be delisted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

in 24 hr

after death; Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7991

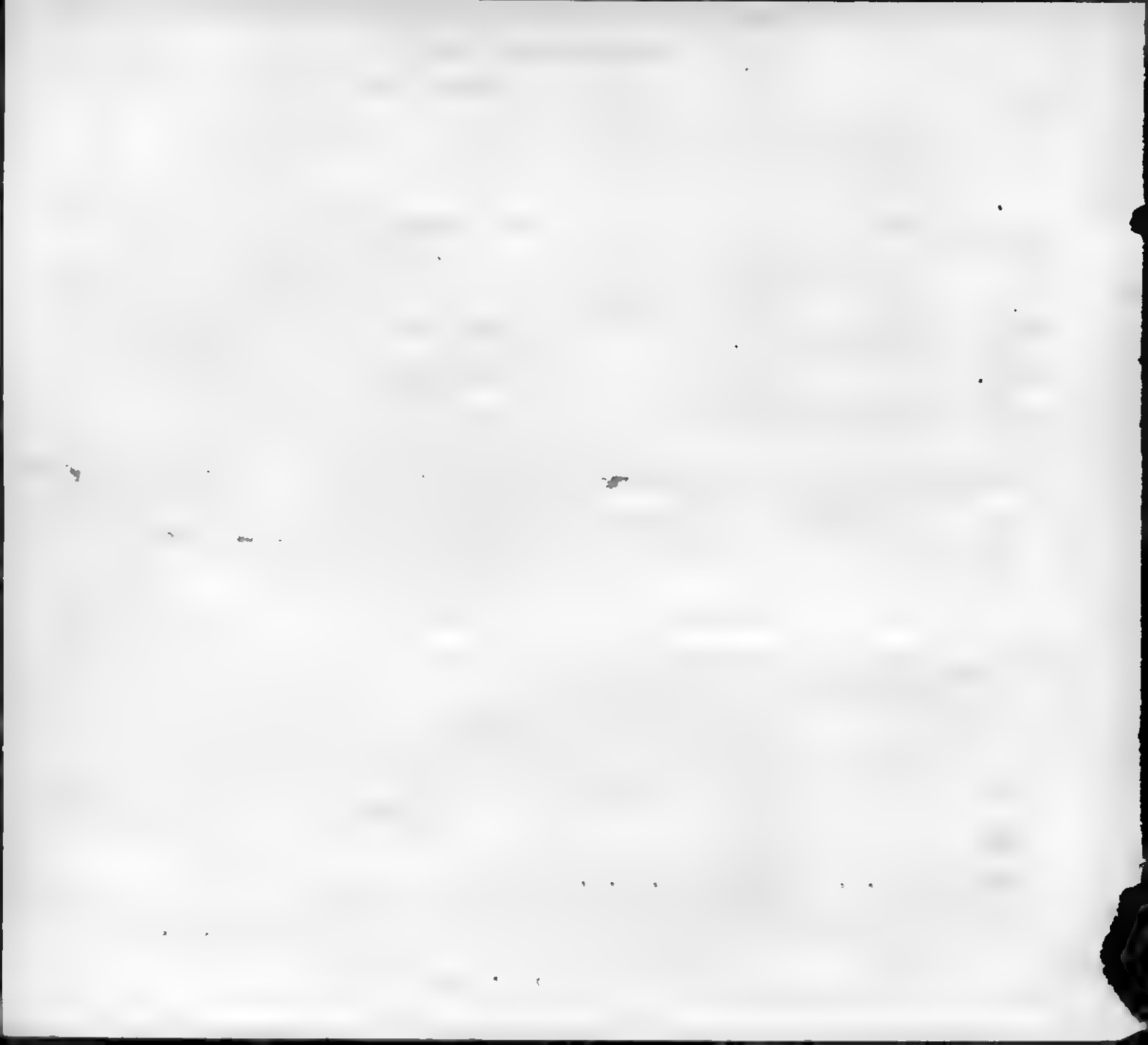
CERTIFICATE OF DEATH

Reg. Dist. No. 07977

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest Samuel BURLIN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. P. Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward K Burlin</u>		14. MOTHER'S MAIDEN NAME <u>Lina B. Shank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>219-05-586</u>	
17. INFORMANT <u>Willard C. Burlin</u>		Address <u>Colora Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>171.2</u> DUE TO <u>Heart attack & long x brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Acute Coronary Artery</u> (c) <u>Syst.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>58</u> , to <u>July 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-3</u> , 19 <u>59</u> , and that death occurred at <u>2:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard C. Burlin</u>		ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>7/3/59</u>	
PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-7-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thompson</u>	

MEDICAL CERTIFICATION

or prior to burial, cremation, or removal, and in any event within 72 hours after death.



7992

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Harford Memorial Hospital		e. STREET ADDRESS 71 Liberty Street	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle L. Last BYRNE		4. DATE OF DEATH Month July Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 10 Days 2 Hours 59 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses-Aid		10b. KIND OF BUSINESS OR INDUSTRY Hospital (APG.)	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Hannah Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220-22-0254	
17. INFORMANT John S. Byrne		Address 610 Walker St. Aberdeen Md.	
18. CAUSE OF DEATH (Enter only one cause per line (a) or (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Congestive Heart Failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Metastatic Carcinoma, both lungs			
DUE TO Carcinoma of Breast			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-2-59 to 7-5-59 , that I last saw the deceased alive on 7-5-59 , and that death occurred at 2:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman		ADDRESS (Street, city or town, state) 8 Law Street	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/59	
22c. NAME OF CEMETERY OR CREMATORY Lewis Family Cemetery		22d. LOCATION (City, town, or county) (State) Massaponax, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring		ADDRESS Tarring Funeral Home, Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE JUL 8 59		24b. REGISTRAR'S SIGNATURE C. L. & K. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, or the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUGE DE GRACE		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELAIR	
3. NAME OF DECEASED (Type or print) John HARRY CHACKNESS		4. DATE OF DEATH July 8 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ✓
9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? Citizen of US	
13. FATHER'S NAME Chris Chackness		14. MOTHER'S MAIDEN NAME CATHERINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 212-14-8213	
17. INFORMANT HARRY CHACKNESS		Address BELAIR MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 165X DUE TO Intermittent Concomitant of the lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Concomitant of the lung DUE TO 2 yrs (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10, 1959 to July 8, 1959 , that I last saw the deceased alive on July 7, 1959 , and that death occurred at 5:55 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ross Z. Pierpont M.D.		ADDRESS (Street, city or town, state) A DATE SIGNED	
PHYSICIAN'S NAME (Type) Ross Z. Pierpont M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10/59	22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL	22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE JUL 10 '59	24b. REGISTRAR'S SIGNATURE Arthur J. Hume

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7994

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
c. LENGTH OF STAY IN 1b <i>3 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>320 Rogers Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Teruise</i> Middle <i>U.</i> Last <i>Pile</i>		4. DATE OF DEATH Month <i>July</i> Day <i>10th</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877</i> 9. AGE (In years last birthday) <i>82</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY <i>USA.</i>	
13. FATHER'S NAME <i>Anthony Janko</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Leiketta</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Nicholas Bourge - 320 Rogers St</i>		Address <i>Aberdeen Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>gastrointestinal hemorrhage of undetermined origin</i> 578X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypoproteinemia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-28</i> , 19 <i>59</i> , to <i>7-10</i> , 19 <i>59</i> that I last saw the deceased alive on <i>6-28-59</i> , 19 <i>59</i> , and that death occurred at <i>10:45</i> P.M., from the causes and on the date stated above			
ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>Aberdeen Md.</i> DATE SIGNED <i>7-11-59</i>	
PHYSICIAN'S NAME (Type) <i>Barry T. Plunkett Jr.</i>		<i>Aberdeen Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>7/11/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Albans</i>	22d. LOCATION (City, town, or county) (State) <i>Buffalo New York</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barring</i> ADDRESS <i>Aberdeen Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 59</i>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8015

CERTIFICATE OF DEATH

07981

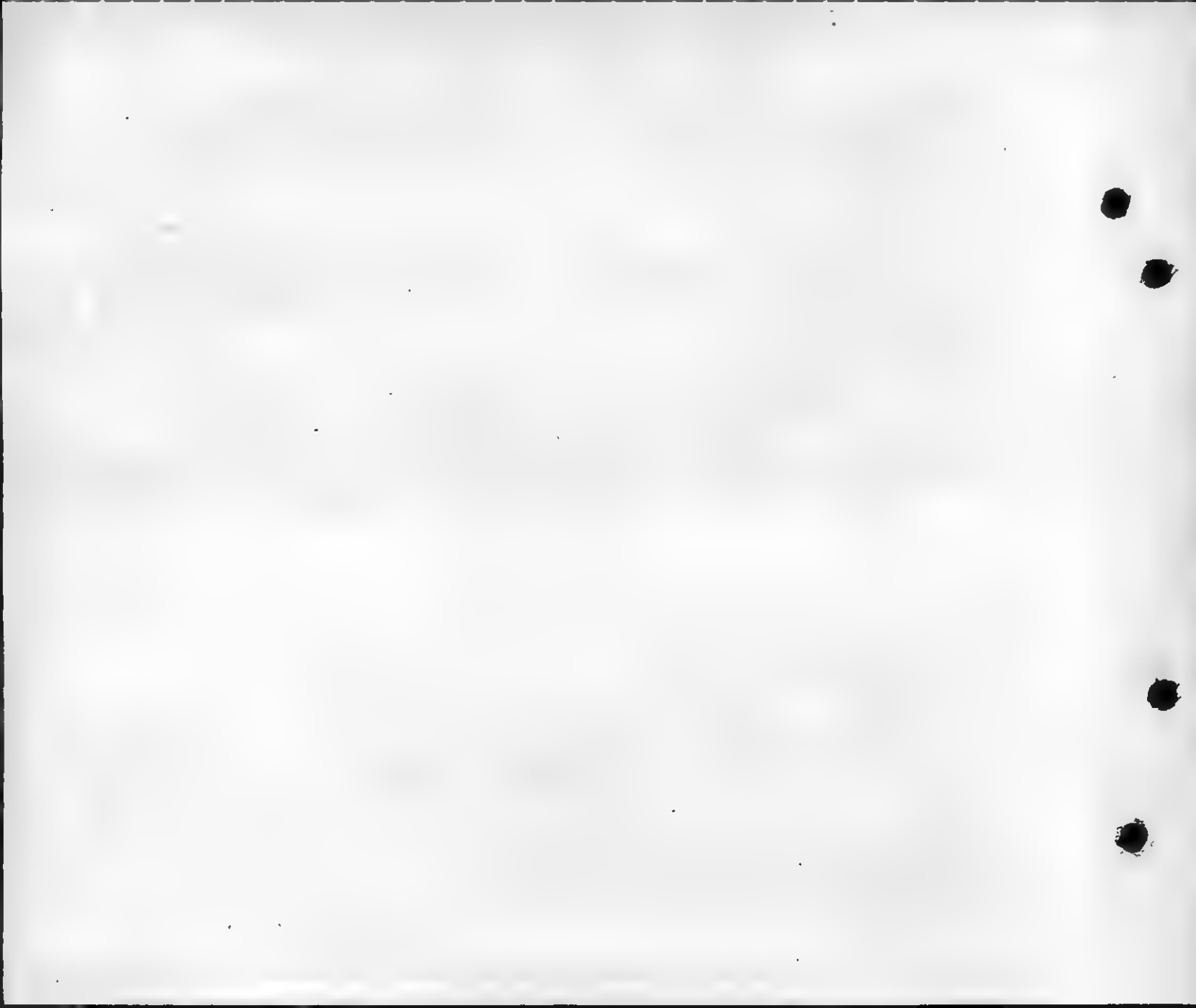
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD	
c. LENGTH OF STAY IN 16 40 YRS.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA ELIZABETH DAVIS		4. DATE OF DEATH Month Day Year JULY 28, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 6, 1880
9. AGE (In years Birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PEACHBOTTOM TWP., PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK DEEVER		14. MOTHER'S MAIDEN NAME LEAH FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. WALTER DAVIS, STREET, MD.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary sclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Artero-sclerosis (generalized) (b) Diabetes mellitus (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 27, 1959 , to July 28, 1959 , that I last saw the deceased alive on July 27, 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jonah G. Hunt M.D.		ADDRESS (Street, city or town, state) Delta, Pa. DATE SIGNED 7/28/59	
PHYSICIAN'S NAME (Type) Hosiah A. Hunt, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-59	
22c. NAME OF CEMETERY OR CREMATORY DUBLIN SOUTHERN		22d. LOCATION (City, town, or county) (State) DUBLIN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison, Delta, Pa. ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u> c. LENGTH OF STAY IN 1b <u>53 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Howard M. Donnan</u> First Middle Last 4. DATE OF DEATH <u>July 4, 1959</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 16, 1889</u> 9. AGE (In years) <u>78</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Donnan</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lane</u> 17. INFORMANT <u>Mrs. Pauline Cooper, Delta R.D., Pa.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>7-5-59</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION (Specify) <u>Burial</u> 22b. DATE THEREOF <u>July 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Rebo</u> 22d. LOCATION (City, town, or county) (State) <u>Delta, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hartman, Delta, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7995

CERTIFICATE OF DEATH

07983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Md b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURDC GRACE				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET GAYLORD				4. DATE OF DEATH Month Day Year July 6 1959			
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 3, 1901	
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Haines				14. MOTHER'S MAIDEN NAME Venus Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Leaters Gaylord, Port Deposit, Md			
17. INFORMANT Leaters Gaylord, Port Deposit, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and thrombosis & left hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebral arteriosclerosis and A.S.C.V.D. DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 8 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 20th, 1959 to July 6th, 1959 , that I last saw the deceased alive on July 6th, 1959 and that death occurred at 10 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Edward C. Loo, M.D.				211 N. Union Ave. 7/6/59			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				Haure de Grace, Md.			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-9-1959		Green Memorial		Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons, Perryville, Md				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 10 1959	
				24b. REGISTRAR'S SIGNATURE Edward S. Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 204 7-20-59 et

CERTIFICATE OF DEATH

07984

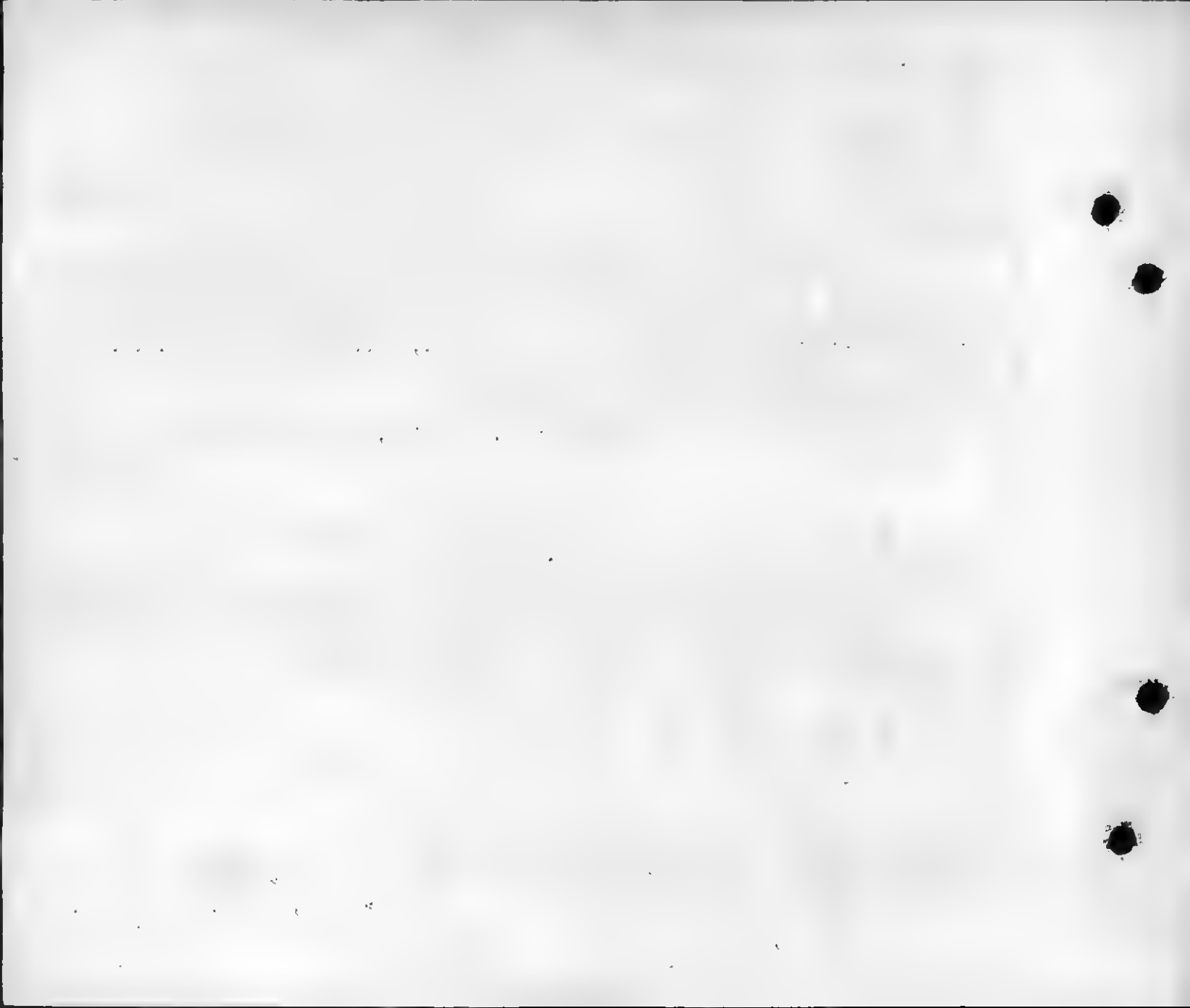
(EMORY W. GOODRICH)

7996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. STREET ADDRESS <u>Willoughby Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Goodrich Emory William</u>				4. DATE OF DEATH Month Day Year <u>July 10 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/00</u>	9. AGE (In years last birthday) <u>58 5/8</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WINFORD Goodrich</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN Sophia MADERY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>717-07-7995</u>		17. INFORMANT Address <u>Rose E. Goodrich, Edgewood Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>July 7th, 1959</u> , to <u>July 10th, 1959</u> , that I last saw the deceased alive on <u>July 10th, 1959</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave., 7/10/59</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				DATE SIGNED <u>7/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Balto., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard M. Brown Jr.</u>				ADDRESS <u>Allegany Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Orlando S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8017

CERTIFICATE OF DEATH

07985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) R.F.D.#2- Box 692		d. STREET ADDRESS R.F.D.#2- Box 692	
3. NAME OF DECEASED (Type or print) Jennie First Middle Last Graham		4. DATE OF DEATH July 24 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1896
9. AGE (In years birthday) 62 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harvey Sinix	
14. MOTHER'S MAIDEN NAME Annea Gild		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. 218-32-3226		17. INFORMANT Charles H. Graham-R.F.D.#2- Box 692 Address Joppa-Harford Co. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO (b) 2 yrs. + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1959 to July 1959 , that I last saw the deceased alive on July 23, 1959 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Tjane M.D.		ADDRESS (Street, city or town, state) Kingsville, Md. 7-24-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF 7-27-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. ADDRESS 2431-35 E. Oliver St.		24a. REC'D BY REGISTRAR JUL 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



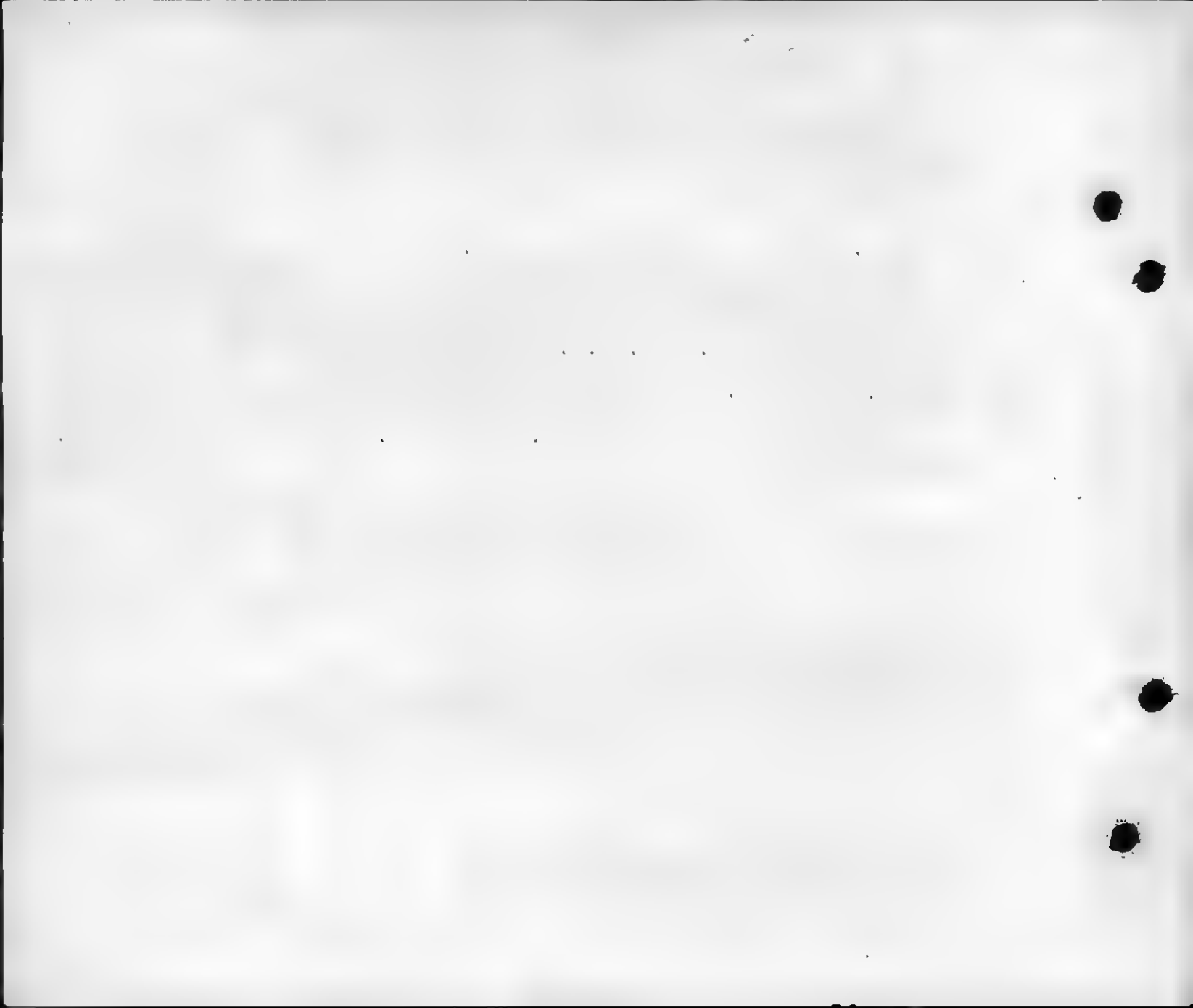
8018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Pikesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>				d. STREET ADDRESS <i>2606 Taylor Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. Frank Dudley Green, Jr.</i>				4. DATE OF DEATH <i>July 8th</i> Day <i>8th</i> Year <i>19 59</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 1, 1886</i>	
9. AGE (In years last birthday) <i>73</i> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B. & O. R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank D. Green Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Susan Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mr. Merrill F. Green</i>				Address <i>7718 Wilson Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis.</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> 19 <i>59</i> , to <i>July 7, 19 59</i> , that I last saw the deceased alive on <i>July 7</i> 19 <i>59</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward W. Hyson</i> M.D.				ADDRESS (Street, city or town, state) <i>Franklin Avenue</i> DATE SIGNED <i>7-8</i>			
PHYSICIAN'S NAME (Type) <i>Edward W. Hyson</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/11/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Hartford Road #14</i>		24a. REC'D BY REGISTRAR <i>JUL 10 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Charles S. Knight</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8019

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlingtton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlingtton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Attlie S. Hanley</u> First Middle Last		4. DATE OF DEATH <u>July 16</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1896</u> last birthday yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Gadsom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> <u>leukemia</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5 yrs</u> <u>4 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10, 1959</u> to <u>July 16, 1959</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>59</u> , and that death occurred on <u>July 16</u> , 19 <u>59</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Barlingtton Md</u> DATE SIGNED <u>7/27/59</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		ADDRESS <u>Barlingtton Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Barlingtton Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Barlingtton Md</u>		24a. REC'D BY REGISTRAR <u>JUL 22 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

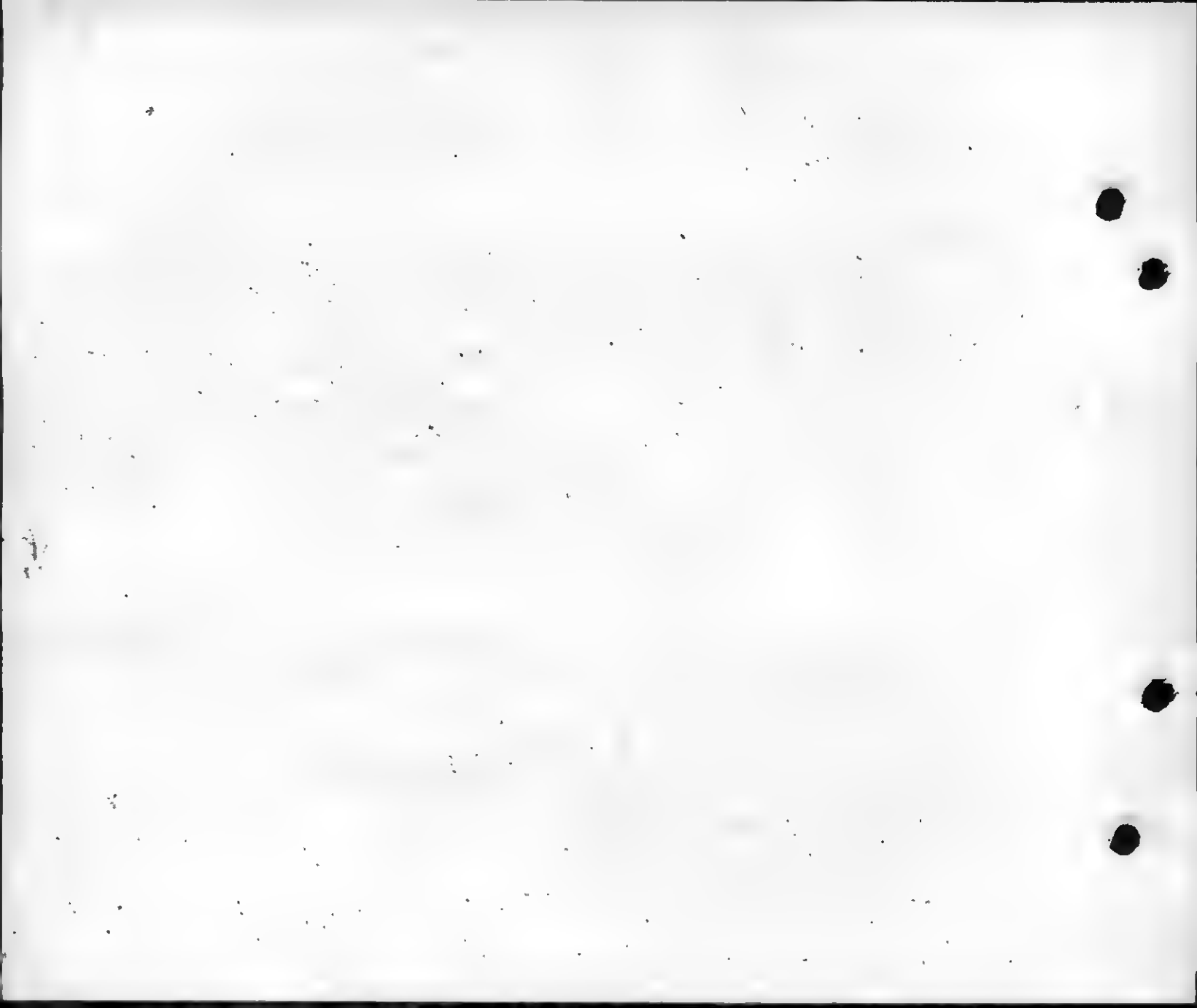
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

7997

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07988

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Courtland Place</u>		f. STREET ADDRESS <u>Forest Hill Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Nathan Reece Harkins</u>		4. DATE OF DEATH <u>July 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-13</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR <u>45</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11. BIRTHPLACE (State or foreign country) <u>Forest Hill Harford Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Calvin W Harkins</u>	
14. MOTHER'S MAIDEN NAME <u>Etta May Barrow</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-63-5722</u>		17. INFORMANT <u>W Harkins</u> Address <u>Forest H. H., Md. Box 306</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Ditch he was digging, caved in on him</u>		20c. TIME OF INJURY Month, Day, Year <u>7-27-59</u>	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Belt Air</u>	
20f. (City or town) <u>Harford Md.</u>		20g. (County) <u>Harford</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-27-59</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenleaf Methodist</u>		22d. LOCATION (City, town, or county) <u>Chestnut Hill Harford Md.</u>	
22e. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Loebe</u>		22f. ADDRESS <u>Belt Air Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designate agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8020

CERTIFICATE OF DEATH

Reg. Dist. No.

07989

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Harry R. James</u> First Middle Last		4. DATE OF DEATH <u>July 28</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1878</u> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md. U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. James</u>		14. MOTHER'S MAIDEN NAME <u>Abigail H. Furrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ADVANCED ARTERIO SCLEROSIS</u> DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>25 JULY</u> , 19 <u>59</u> , to <u>28 JULY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 JULY</u> , 19 <u>59</u> , and that death occurred at <u>8:35 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Sidwell</u>		ADDRESS (Street, city or town, state) <u>401 Franklin St. Baltimore</u> DATE SIGNED <u>29 July 59</u>	
PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL M.D.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>July 31, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Burlington</u>		22d. LOCATION (City, town, or county) <u>Harford Co. Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>JUL 31 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	



Reg. Dist. No. _____

2. 'Buxvi

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7999

CERTIFICATE OF DEATH

Reg. Dist. No. 07991

1. PLACE OF DEATH o COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	
c. LENGTH OF STAY IN TB 10 DAYS		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		1 d. STREET ADDRESS 742 OTSEGO	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Clifford Jones		4. DATE OF DEATH Month Day Year July 27 1959	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 4 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Ellen Celesta Bowser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, and or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO —	
17. INFORMANT Mrs. Marie Jones - Harde Grace Md.		Address 742 Otsego St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Hypertensive—Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17, 1959 , to 7/26, 1959 , that I last saw the deceased alive on 7/26, 1959 , and that death occurred at 1:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Stansbury		DATE SIGNED 7/28/59	
PHYSICIAN'S NAME (Type) George T. Stansbury		ADDRESS (Street, city or town, state) 589 Revolution St. Harde Grace Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-30-59	22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Kinn		ADDRESS Charles S. Kinn	
24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

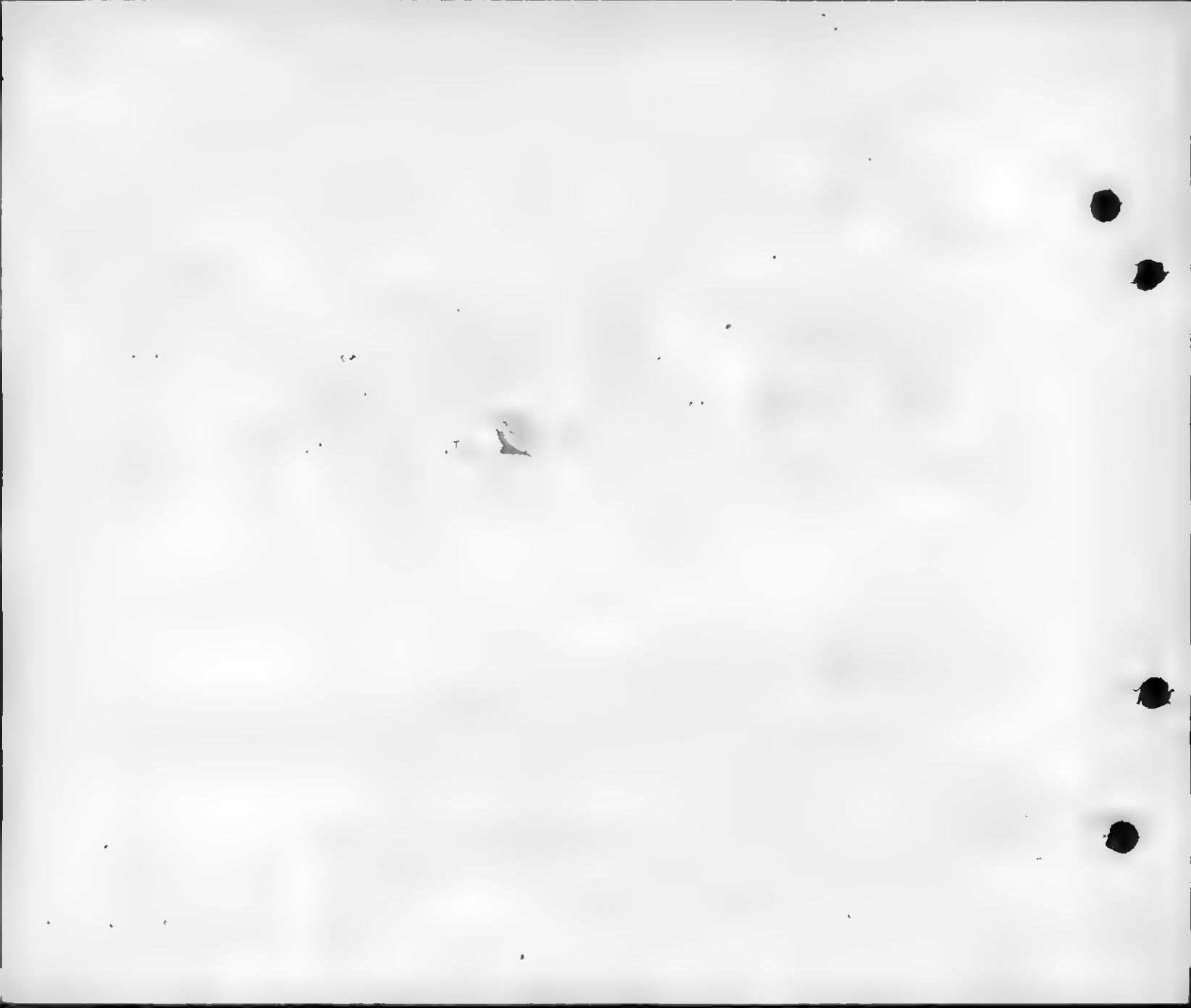
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07992**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS RD 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penn RR tracks		e. RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard N Kilduff	4. DATE OF DEATH July 7 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1937
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7	11. IF UNDER 24 HRS Hours 59 Min 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Rubber	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Eugene J. Kilduff, Sr.,		14. MOTHER'S MAIDEN NAME Margaret Nolan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 256-1959	
17. INFORMANT Eugene J. Kilduff, Sr.,		Address Aberdeen, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation (b) 10 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auto accident, auto-train type			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Auto accident, auto-train type	
20c. TIME OF INJURY Month, Day, Year 7-7-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Penn RR tracks		20f. (City or town) Perryman (County) Harford (State) MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air	
EXAMINER'S NAME (Type) Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> W	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Francis		22d. LOCATION (City, town, or county) Abingdon, Harford, Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McHenry		24a. REC'D BY REGISTRAR AUL 13 '59	
ADDRESS Abingdon, Maryland.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

8022

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07993

Items 10, 12, etc., Fill G246 8-18-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Joppa</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Joppa</u> d. STREET ADDRESS <u>Helms Motel</u> e. RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Felix Marx</u> First Middle Last 4. DATE OF DEATH <u>July 23</u> Month Day Year <u>19 59</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 12, 1902</u> 9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u> 11. BIRTHPLACE (State or foreign country) <u>?</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u> 14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>"Maryland State Police investigated."</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> 22a. BIRTHAL, CREMATION REMOVAL (Specify) <u>Removal</u> 22b. DATE THEREOF <u>July 29, 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>University Hospital</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>7-23-59</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. The Crown</u> ADDRESS <u>Abingdon Md</u> 24a. REC'D BY REGISTRAR <u>?</u> DATE <u>AUG 5 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

8000

Reg. Dist. No.

07994

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>Quarry Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Lucida</u> Last <u>Mash</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1892</u>
9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>16</u> Days <u>7</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Bernard Teipe</u>		14. MOTHER'S MAIDEN NAME <u>Anna Beible</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213-36-7745</u>	
17. INFORMANT <u>Margaret Mash</u>		Address <u>Havre de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-20</u> 19 <u>59</u> , to <u>7-20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2:50 A.M. 7-19-59</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cunther D. Hirsch</u>		ADDRESS (Street, city or town, state) <u>421 Gress Av. HAVRE DE GRACE MD.</u>	
PHYSICIAN'S NAME (Type) <u>CUNTER D. HIRSCH</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>David Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Macgownski</u>		ADDRESS <u>2525 Fleet St. Balto. 24, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8001

CERTIFICATE OF DEATH

Reg. Dist. No.

07995

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>296 Paradise Rd.</u>				e. STREET ADDRESS <u>296 Paradise Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Alberta</u> Last <u>Melville</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30th</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>Andrew Jackson Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn R. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Beauregard Perkins, Jr. Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA, Probable</u> DUE TO <u>(1) Hypertensive Cardiovascular Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Disease</u> (c) <u>(2) Carcinoma, breast, probably metastatic</u>							INTERVAL BETWEEN ONSET AND DEATH <u>HRS</u> <u>MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>58</u> to <u>July 30</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>William H. Kirby Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>617 W. Bel Air Ave</u>			
DATE SIGNED <u>7/31/59</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Barry J. Plunkett, Jr.</u>				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Alesia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blue E. Barron</u>				ADDRESS <u>Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8002

CERTIFICATE OF DEATH

Reg. Dist. No.

07996

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>314 Bourbon ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Hensley Milton</u>		4. DATE OF DEATH <u>JULY 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1871</u>
9. AGE (In years, last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILTON HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-10-6063</u>	
17. INFORMANT <u>Bertha Magey</u>		Address <u>355 Glen St. Hdr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 yrs.</u> <u>4-5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15th, 1959</u> to <u>July 16th, 1959</u> , that I last saw the deceased alive on <u>July 16th, 1959</u> and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Havre-de-Grace, Md.</u>		DATE SIGNED <u>7/16/59</u>	
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke Co., VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Madison Mitchell</u>		ADDRESS <u>Havre-de-Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07997									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Havre de Grace Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First DAVID Middle OSBORNE Last OSBORNE					4. DATE OF DEATH Month July Day 27 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9 1950		9. AGE (In years last birthday) 8 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Fountain View Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William E. Osborne					14. MOTHER'S MAIDEN NAME Shirley Morris				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. E. Osborne Address Havre de Grace Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus 525X DUE TO due to Interstitial Pneumonitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Charles S. Petty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					DATE SIGNED 7/27/59				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/29/59		22c. NAME OF CEMETERY OR CREMATORY Bellin Mm. Garden			22d. LOCATION (City, town, or county) (State) Bellin Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence R. Hancock					24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial-cremation, or removal.



8004 Items 8 & 9, Form 10-247 9/1/54, c.c.
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE				c. LENGTH OF STAY IN 1b 25 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS Main St.			
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE Elizabeth Patrick				4. DATE OF DEATH Month Day Year July 21 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/4/97	
9. AGE (In years last birthday) 62 1/2 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Russell County, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WALTER HUBBARD				14. MOTHER'S MAIDEN NAME JOSEPHINE E. COX			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 220-05-5012		17. INFORMANT Mrs. Arthur Helton Address Box 335, Bel Air RD #2 Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) > 10 years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 25 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25 1959 to July 21 1959 that I last saw the deceased alive on July 21 1959 and that death occurred at 5:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 N. Union Ave. Bel Air, Md. DATE SIGNED 7/21/59							
ACTUAL SIGNATURE Edward C. Loo, M.D.				PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. Harve de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Fater ADDRESS W. Broadway and Williams St. Bel Air, Maryland				24a. REC'D BY REGISTRAR Aug 23 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MSM
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Penn</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Philadelphia</u> <u>4547 Colorado St</u>	
3. NAME OF DECEASED (Type or print) <u>Norman Randolph Pond III</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BRVN MAURT PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NORMAN P POND JR</u>		14. MOTHER'S MAIDEN NAME <u>EDITH VA HARBURN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>252-64-6011</u>	
17. INFORMANT <u>FATHER</u>		Address <u>3014 KINSINGTON AVE, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-18-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Towson</u>		20f. (City or town) <u>Harford Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Levell C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7-18-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>		22d. LOCATION (City, town, or county) <u>RICHMOND VIRGINIA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Tawney</u>		24a. REC'D BY REGISTRAR <u>Charles S. Tawney</u> DATE <u>JUL 21 '59</u>	



8005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
c. LENGTH OF STAY IN 1b <u>2 days</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1. d STREET ADDRESS <u>R.O.# 1</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Harry Henry Rembold</u>				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. UNMARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 16 / 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? _____							
13. FATHER'S NAME <u>John Rembold</u>				14. MOTHER'S MAIDEN NAME <u>Matilda</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. <u>212-10-9995</u>			
17. INFORMANT <u>Harry Henry Rembold</u> Address <u>Bel Air Rd Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>P.O. shock</u> + 41.0 DUE TO <u>Quadruple ulcer, hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 27, 1959</u> , to <u>July 29, 1959</u> that I last saw the deceased alive on <u>July 29, 1959</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7-29-59</u>							
ACTUAL SIGNATURE <u>Joseph J. Fisher</u> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1 / 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Green Chapel Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Fisher</u> ADDRESS <u>Bel Air Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8006

CERTIFICATE OF DEATH

Reg. Dist. No.

08001

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d STREET ADDRESS <u>212 N. Freedom Alley</u>	
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Gane</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Collins - Nec.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17 INFORMANT <u>Eugene Richardson</u>		Address <u>565 St Clair St. HDB</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4/1/59</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>5/25</u> , 19 <u>59</u> , to <u>7/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>2:40</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St Harre de Grace, Md</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>7/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Bullock</u>		ADDRESS <u>Harre de Grace, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Bullock</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



08002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>md</u> <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B</u> Last <u>Rinehart</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Towson, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Rinehart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>213-12-8807</u>	
17. INFORMANT <u>Mrs., Emma F. Rinehart, Abingdon, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>July 7, 1959</u> that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>238</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Balto., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8025 CERTIFICATE OF DEATH

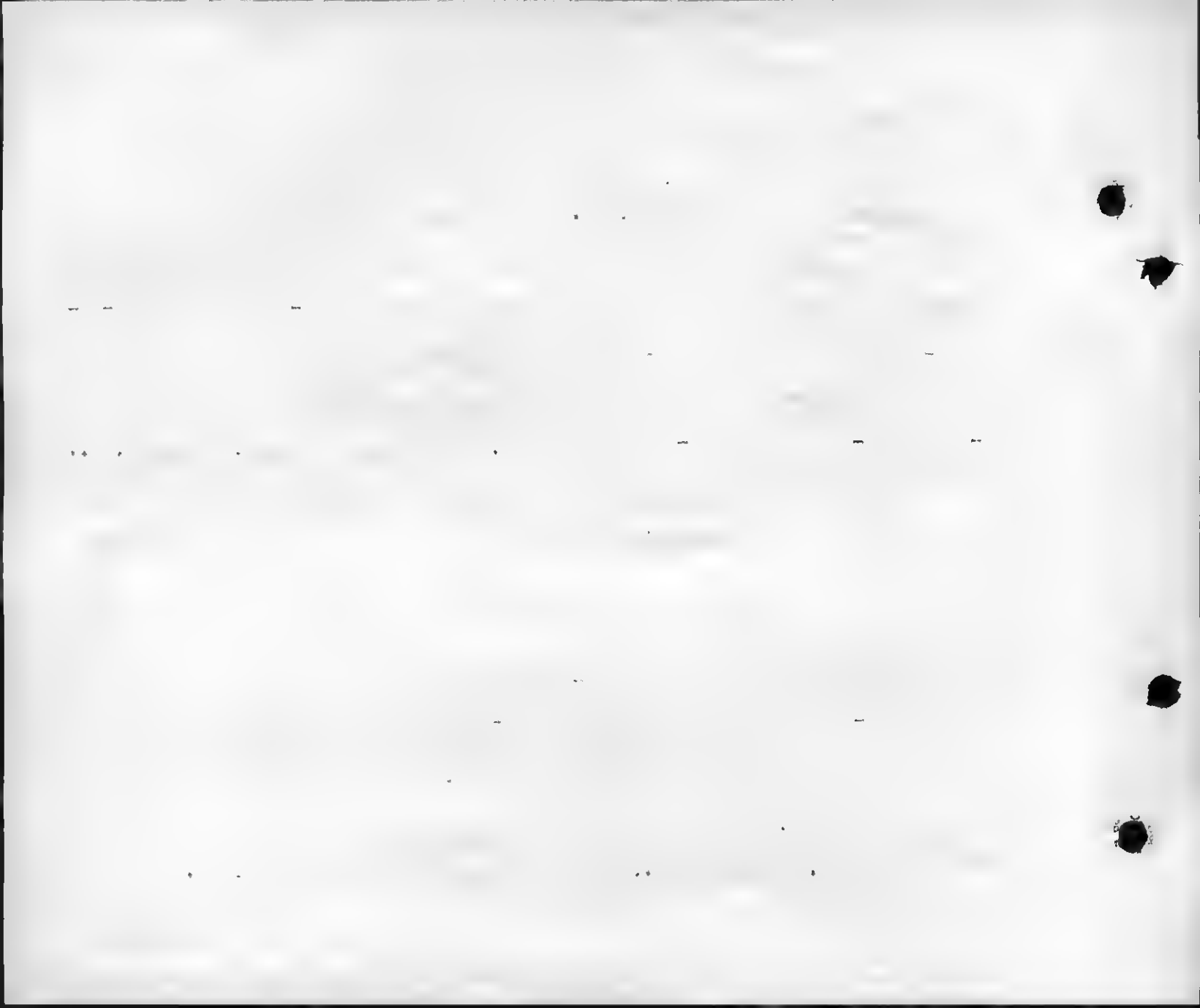
Reg. Dist. No.

08003

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMY Middle JO Last RIST		4. DATE OF DEATH Month July Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1959
9. AGE (In years last birthday) — yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days 5 Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Clinton Rist		14. MOTHER'S MAIDEN NAME Betty Rose Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO —	
17. INFORMANT JOHN C. RIST, Father		Address 11 E Rieder Court, Edgewood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CNS disease, congenital & Pulmonary congestion 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 July , 19 59 , to 8 July , 19 59 , that I last saw the deceased alive on 8 July , 19 59 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Fraher M.D.		US Army Hospital Aberdeen Proving Ground, Md.	
PHYSICIAN'S NAME (Type) THOMAS J. FRAHER, Capt., MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/1959	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Army & Naval Center, Md
23. FUNERAL DIRECTOR'S SIGNATURE John E. Barring ADDRESS Aberdeen, Maryland		24a. REC'D BY REGISTRAR DATE JUL 13 59	24b. REGISTRAR'S SIGNATURE Arthur L. France

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8026

CERTIFICATE OF DEATH

Reg. Dist. No.

18004

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle EDWARD Last ROBINSON				4. DATE OF DEATH Month July Day 27 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1 Jan 1903	
9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Frank E Robinson		14. MOTHER'S MAIDEN NAME Maggie Ramer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO WW II Korean Unknown		17. INFORMANT Clair Robinson		Address 613B Front Street Clearfield, Pa		18. INTERVAL BETWEEN ONSET AND DEATH 4 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 904.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURED ribs and pneumothorax DUE TO (c) Pulmonary emphysema and alcoholism				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with history of failure			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Unknown			
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 July 1959 , to 27 July 1959 , that I last saw the deceased alive on 11:30 AM 27 Jul, 19 59 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 27 Jul 59							
ACTUAL SIGNATURE D. HAMATY Capt MC M.D.				PHYSICIAN'S NAME (Type) US Army Hospital Aberdeen Proving Ground, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/29/59		22c. NAME OF CEMETERY OR CREMATORY Bigler Cemetery		22d. LOCATION (City, town, or county) (State) Bigler, Clearfield Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barry				24a. REC'D BY REGISTRAR DATE JUL 30 1959			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8027 **CERTIFICATE OF DEATH**

08005

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Whiteford</u>		LENGTH OF STAY (in this place) <u>50yrs. +</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Whiteford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Benjamin Archer Ross</u>				4. DATE OF DEATH 7 9 19 59			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>25 July, 1875</u>	
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Cecil Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>urkn.</u>		16. SOCIAL SECURITY NO. <u>220-01-1796</u>		17. INFORMANT & ADDRESS <u>Mrs. Helen Jones, Whiteford, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Lobar pneumonia - bilateral</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute congestive failure</u>				<u>5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular disease</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7</u> , 19 <u>59</u> , to <u>July 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8 July</u> , 19 <u>59</u> , and that death occurred at <u>11:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edwin W. Whiteford Jr M.D.</u>				ADDRESS (Street, city, town, state) <u>Whiteford Md</u>			
DATE SIGNED <u>9 July 59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 12, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Slate Ridge</u>		LOCATION (City, town, or county) (State) <u>Delta, Penna</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harline</u>		ADDRESS <u>Delta, Penna</u>	

INSTRUCTIONS

1 **1**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8028

CERTIFICATE OF DEATH

08006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES HENRY ST CLAIR		4. DATE OF DEATH July 20 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Engineer		10b. KIND OF BUSINESS OR INDUSTRY US Army	9. AGE (In years last birthday) 59
11. BIRTHPLACE (State or foreign country) Lansing, Michigan		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frank St. Clair		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-12-7902	
17. INFORMANT BERTHA ST CLAIR (Wife)		Address 106 A Rodman Rd Aberdeen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion (History of angina and heart disease) 420.1 DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 40 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA , 19____, and that death occurred at 1000 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Jerome B. Bryant, Jr. M.D.		US Army Hospital Aberdeen Proving Ground, Maryland	
PHYSICIAN'S NAME (Type) Jerome B. Bryant, Major MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/59	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barry		24a. REC'D BY REGISTRAR 24 59	24b. REGISTRAR'S SIGNATURE John G. Barry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8007 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>309 ST. JOHN ST.</u>				STREET ADDRESS (If rural give location) <u>309 ST. JOHN ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>EDGAR SPEAR SHARER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 11 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 6 1900</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>F. GEO. MEADE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES B. SHARER</u>				14. MOTHER'S MAIDEN NAME <u>DOLLY MAE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-07-0860</u>		17. INFORMANT & ADDRESS <u>MRS. LEOA E. SHARER</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) DUE TO				<u>Pneumonia, Cholera</u>		<u>1 hour</u>	
ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Coronary Occlusion</u>		<u>1 hour</u>	
				<u>Chronic Myocarditis</u>		<u>2 years</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUL 10</u> , 19 <u>59</u> , to <u>JUL 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUL 11</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walbert M.D.</u>				ADDRESS (Street, city, town, state) <u>Havre de Grace Md</u>			
DATE SIGNED <u>JUL 13 1959</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>7-14-1959</u>		NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>CUMBERLAND MD</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>		REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Madison Minter</u>		ADDRESS <u>Havre de Grace, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-1



may be retained by the hospital ending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bal Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 1 week		d. STREET ADDRESS 5913 Karon Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise Simpson		4. DATE OF DEATH Month Day Year July 7 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1877
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Schweikart		14. MOTHER'S MAIDEN NAME Caroline Muth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Minnie Horner		Address 5913 Karon Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4 hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio-vascular Disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 , 19 59 , to July 7 , 19 59 , that I last saw the deceased alive on July 6 , 19 59 , and that death occurred at 4:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED July 7, 1959			
ACTUAL SIGNATURE Willard P. Hudson			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/10/59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Anthony Miller ADDRESS 2334 Jefferson St.		24a. REC'D BY REGISTRAR DATE JUL 9 '59	24b. REGISTRAR'S SIGNATURE Carlton L. Hines



8009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>			
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>				d. STREET ADDRESS <u>142 WILLIAMS ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRITZ</u> <u>TENNINGS</u> <u>STERBAK</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>10</u> <u>19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/19/59</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>1</u> <u>1</u> <u>1</u>		IF UNDER 24 HRS <u>1</u> <u>1</u> <u>1</u> <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRITZ VINCENT STERBAK</u>				14. MOTHER'S MAIDEN NAME <u>AUDREY SCARBOROUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>FRITZ V. STERBAK, BELAIR, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal insufficiency</u> DUE TO <u>277X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congenital adrenogenital syndrome</u> DUE TO <u>hypoparathyroidism - secondary cause</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>7/10</u> , <u>19 59</u> , and that death occurred at <u>4:30 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>THEODORE H. KAISER</u> <u>7/10/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>7-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR GARDENS</u>	
22d. LOCATION (City, town, or county) (State) <u>BELAIR, MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Bel Air, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18009

8010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELAIR				c. LENGTH OF STAY IN 1b 4 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 REED ST.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 DELAIR			
f. STREET ADDRESS 104 REED ST.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH M. STREETT				4. DATE OF DEATH Month Day Year JULY 6, 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		11. BIRTHPLACE (State or foreign country) ROCKS, MD.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROCKS, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. STREETT				14. MOTHER'S MAIDEN NAME FLORA MITCHELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT Address ELIZABETH K. STREET 104 REED ST. DELAIR, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Uremia DUE TO consequences of the kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prostatic cancer DUE TO (c) prostatic cancer							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1957 to 1959 , that I last saw the deceased alive on July 5, 1959 , and that death occurred at MD. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cardiff, Maryland DATE SIGNED 7/15/59							
ACTUAL SIGNATURE BENJAMIN DOROSI, M. D.				PHYSICIAN'S NAME (Type) Cardiff, Maryland			
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-9-59		22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		22d. LOCATION (City, town, or county) (State) ROCKS, HARFORD CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hopkins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE JUL 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8011

CERTIFICATE OF DEATH

Reg. Dist. No.

08011

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Chapin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hane de Bree</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>22 hrs 31</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chapin Men. Hospital</u>		d. STREET ADDRESS <u>Paradise Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (LAST) <u>Taylor</u> (FIRST) <u>Florence</u> (MIDDLE) <u>Genevieve</u>	4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew S. Jessup</u>		14. MOTHER'S MAIDEN NAME <u>Florence Schmiedly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>William C. Taylor</u>		Address <u>Paradise Rd. Aberdeen, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Rheumatic Heart disease with Mitral Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I attended the deceased from <u>July 13</u> , 19 <u>59</u> , to <u>July 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.		
ADDRESS (Street, city or town, state) <u>John H. Tarring</u>		DATE SIGNED <u>7/21/59</u>
ACTUAL SIGNATURE <u>George W. Sontos</u>	M.D. <u>John H. Tarring</u>	
PHYSICIAN'S NAME (Type) <u>George W. Sontos, M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>
22d. LOCATION (City, town, or county) <u>Perryman, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		
24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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